Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000210	A. BUILDING: _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH LOGAN HEALTHCARE CENTER	801 NORTH LOGAN AVENUE DANVILLE, IL 61832

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S 000	Initial Comments Incident Report Investigation to incident of 6-29-16/IL86808 - F223	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations are not met as evidenced by:

Based on observation, record review, and interview, the facility failed to protect one (R4) of three residents reviewed for abuse from physical and verbal abuse. This failure resulted in R4 being repeatedly physically forced to sit in the wheelchair causing injury with bleeding to the right lower arm.

The finding includes:

According to R4's July 2016 Physician Order Sheet (POS), R4 is 101 years old and has diagnoses of Dementia, Anxiety, Depression, and Hypertension. R4's 5-4-16 Annual Resident Assessment Instrument (RAI) documents that R4 has a hearing difficulty, has delusions, has behaviors of striking out and has verbal behaviors toward others. R4 is severely cognitively impaired and requires assist of one with all activities of daily living (ADLs), R4 requires assistance with balance and uses a wheelchair.

The facility's incident dated 7-1-16 completed by E2, Director of Nurses, documents that E11, a former Laundry Aide, reported to the nurse on 6-29-16 at 8:45 P.M. that E10, Certified Nurse Assistant (CNA) reacted in an inappropriately matter to R4. The incident report stated that it occurred in the Second Floor East Dining Room around 8:00 P.M.

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E2 was interviewed on 7-13-16 at 8:40 A.M. E2 stated that E2 conducted the investigation. E2 stated that E2 got a call from E12, Licensed Practical Nurse at approximately 9:30 P.M. E12 told E2 of the incident in the dining room. E2 directed E12 to get a statement from E10 and tell E10 to clock out and go home. E2 stated that E2 came to the facility. E2 stated E2 was acting in the absence of E1, Administrator.

According to E2 written investigation notes, E2 interviewed E11 on 6-29-16 at 10:55 P.M. E 11 told E2 that at approximately 8:10 P.M., E11 went to the second floor to clean the lounge (dining room) on the east hall, E11 stated that she saw E10 forcefully kick and spin R4's wheelchair around and was smacking at R4 when R4 would try to hit E10. E11 states that E11 witnessed and heard E10 tell R4 to sit down. E10 said it nicely then R4 attempted to stand up again and E10 raised E10's voice and stated in loud voice to R4 "Sit down". E11 stated R4 kept trying to stand up so E10 tried to take R4 over to the table. E11 states R4 started hitting E10 on E10's arm and E10 slapped at R4's arm trying to push R4 away. E11 states after E10 got R4 to the table R4 kept trying to move, so E10 forcefully kicked wheelchair and grabbed the handles of wheelchair to spin R4 around so R4 would be facing the opposite direction. E11 stated E11 was unsure if this was abuse or just inappropriate from what E11 witnessed. E11 reported incident to E13, CNA who instructed E11 to go to the nurse. E11 stated E11 then went to E12, LPN within about 30 to 45 minutes to report incident.

E2 interviewed E12, LPN on 6-29-16 at 11:00 P.M. E12' interview statement includes that at approximately 9:30 P.M. E11 approached E12 in regards to what E11 believed was inappropriate

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behavior of E10 towards R4. E12 stated that shortly before E11 approached E12, E14, CNA and E10 reported to E12 that R4 had scratch on R4's right arm. E12 states that E10 brought R4 up to the nurse's station at approximately 8:45 P.M. to tell E12 that R4 had a scratch on her arm. E12 states that when E12 asked E10 what happened to R4's arm, E10 stated E10 had no idea what could have happened. E12 asked R4 and R4 was unable to recall what happened to R4's arm. E12 stated after E11 reported E11's concern, E12 went to explain to E10 that there has been an allegation about E10's behavior towards R4 and E12 will be sending E10 home. E12 states that E10 began trying to explain what happened and stated "I was just trying to hold R4's arms down". E12 told E10 to clock out and E12 would be contacting E2.

During the interview with E2 on 7-13-16 8:40 A.M., E2 said that E10 did abuse R4 and E10 was terminated. E2 said that E11 was also terminated because of the delay in reporting the allegation. E2 stated that the facility has a video of the abuse. E2 stated that it is hard for E2 to look at the video evidence. E2 offered to show the video evidence to the surveyor. E2 stated that R4 had a long sleeved shirt on and the R4's blood soaked through the sleeves when R4 was taken to E12.

The video was viewed on 7-13-16 starting at 11:10 A.M. The time stamp on the video started at about 8:19 P.M. until 8:37 P.M. E11 was not in the dining room the entire time of the video. Beside what was reported by E11, E10 exhibited additional actions toward R4. At least eight times during the video, R4 was seen standing at R4's wheelchair and E10 would pull R4 back down to the wheelchair. E10 would grab the waist in the

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S9999	Continued From page 4 back of R4's pants. E10 would pull hard enough to force R4 into her wheelchair. E10 pulled R4's wig off of R4's head. At least two times E10 jerked and pushed R4 very firmly. E10 was observed many times pushing and pulling R4's arms. E10 was holding on to R4's from behind R4. The facility's "Abuse Prevention" policy dated 8-10-11 states that the facility will provide each resident with an environment that is free of abuse. (B)	S9999		